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BRONCHOSCOPY AS AN AID IN THE DIAGNOSIS AND TREATMENT OF ASTHMA*

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The medical profession generally today fully appreciates the association of hay fever and bronchial asthma. The part that sensitization plays in asthma is also well understood, and is very properly the first thing to be investigated and may give the information that will lead to curative treatment. Osler, in his ninth edition says, "We have no knowledge of the morbid anatomy of true asthma. In long standing cases, the lesions are those of chronic bronchitis and emphysema." A patient presenting himself with a cough, a wheeze, a history of asthmatic attacks and evidences of emphysema receives sensitization tests. If tests are positive and appropriate treatment instituted, he may be cured. If he does not react to the test he is labelled "asthmatic, non-sensitive group," and is treated for "asthma". So many of these cases have been referred for bronchoscopic study and on direct examination there have been found foreign body, cicatricial stenoses, cancer or other organic lesions of the larynx, trachea, bronchi, or mediastinum that Dr. Jackson has coined the paraphrase, "all is not asthma that wheezes."

Bronchoscopic aid in diagnosis. The development of a bronchoscopic technic by which a direct examination of the larynx, bronchi, and trachea can be made with a sedative and local anesthesia in adults, and a sedative only, no anesthesia, in children, makes this procedure applicable in practically all cases.

DIFFERENTIAL DIAGNOSIS

Foreign Bodies. Foreign body in the trachea bronchial tree or esophagus may produce an ex-

piratory wheeze, "the asthmatic wheeze" of foreign body. Many patients have been sent in to the bronchoscopic clinic, that had been treated for asthma, and on examination we have found a foreign body in the larynx, trachea, bronchi, or esophagus. The removal of the foreign body cured the "asthma".

An illustrative case may be cited. A child, nine months of age, was admitted to the Bronchoscopic Clinic at the Graduate Hospital with a marked expiratory wheeze, emphysematous chest, some dyspnea on exertion, with no difficulty in swallowing liquids. There was a history of his having choked on a chicken bone one week before admission, and following this, a persistent wheeze was noticed. X-ray examination was negative for both opaque and nonopaque foreign body. An opaque mixture passed readily through the esophagus (Fig. 1). There was present, however, emphysema of both lungs. Dr. Howard C. Carpenter, on examination, advised bronchoscopic study to exclude foreign body. On bronchoscopy, a compression stenosis of the trachea was found just above the bifurcation, and an esophagoscopy was done and a large portion of bone (Fig. 2) was found and removed from the esophagus just above the level of the suprasternal notch. The asthmatic symptoms were entirely relieved by the removal of the foreign body. This is not an isolated case. In another case, a boy aged 6 years who was "an asthmatic" choked on a grain of corn and immediately developed asthmatic symptoms. He was treated for asthma for ten days until his condition became so serious that he was referred to the Clinic for examination. On bronchoscopy a greatly swollen grain of corn was removed from the trachea and the asthmatic attack cured. Jackson states that "diagnosis of asthma in a child should never be made without first excluding foreign body as a diagnostic possibility."¹ In another case a young woman, 24 years of age, developed an expiratory wheeze and cough, immediately following tonsillectomy under ether anesthesia. Examination of her chest

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*From the Chevalier Jackson Bronchoscopic Clinics, the Graduate and University Hospitals of the University of Pennsylvania.

¹Read before the Medical Society of Delaware, Rehoboth, Sept. 12, 1928.

showed slight emphysema. The recovery from the tonsillectomy was otherwise uneventful. A diagnosis of asthma was made and for a period of nine months she was treated by a number of physicians for asthma; all sensitization tests were negative. It occurred to her finally that she had lost a gold crown from a molar tooth about the time of her tonsillectomy. She mentioned this to her attending physician, and X-ray examination of her chest was made and the crown of the tooth was found in the right lung. On bronchoscopic examination the gold crown was found in the right main bronchus and was removed bronchoscopically. The patient's "asthma" immediately disappeared. This case illustrates also the value of X-ray examination. Careful X-ray studies should be made in every case of asthma.

CANCER OF THE LARYNX, ETC.

Cancer of the larynx, trachea, or bronchi may produce asthmatic symptoms. Many cases have been examined where asthmatic symptoms were manifest, and on direct examination an ulcerative lesion was found and a specimen of tissue removed bronchoscopically. Histologic examination showed the lesion to be cancer. A man 45 years of age was admitted to Dr. Stengel's Service at the University Hospital, with a wheeze and a history of having been treated for asthma for one year before admission. Physical examination and X-ray gave evidence of a lesion in left upper lung. Bronchoscopy showed a fungating, ulcerative lesion of the left bronchus and removal of a specimen showed cancer. (Figs. 3 and 4).

Organic stenoses from other causes have been demonstrated bronchoscopically. Cicatricial stenosis of the bronchus, compression stenosis of the trachea, bronchi, from mediastinal tumor, compression stenosis due to aneurism have all been demonstrated bronchoscopically to be the cause of asthmatic symptoms.

Bronchoscopy in true asthma. Bronchoscopy in true asthma shows variable findings. A large number of bronchoscopies have now been done by a number of skilled bronchoscopists and their observations have been reported. Among the bronchoscopists who have reported observations may be mentioned Keiper, Freudenthal, Jackson, Moore, Lukens, Orton, Green, Clerf, Myerson and others. The abnormalities noted are changes in the normal, rhythmic motility of the tracheo-

bronchial tree. This may be manifest as a fixity of the bronchus with normal expiratory narrowing of the lumen, or there may be an abnormal expiratory closure of the bronchus. This is more marked on cough when the posterior wall of the trachea and bronchi may be pushed forward until it comes in contact with the anterior wall. Changes in the mucous membrane, considerable thickening with chronic inflammatory change in the mucosa are common. There may, however, be acute urticarial swellings, and local infiltrations. The mucosa is sometimes pale, and at other times cyanotic, being purplish in appearance. The character and quantity of the secretion varies. As frequently seen, a pearly, tenacious secretion is usually associated with a pale mucosa. If there is marked tracheobronchitis the secretion may be purulent. It is usually quite tenacious and is aspirated with difficulty. The ability to remove mechanically by aspirating the obstructing secretions, is one of the most important contributions of the bronchoscope in treatment. The spasm considered a part of asthma is not noted in the larger bronchi.

Bronchoscopy for treatment. Every case of asthma should be thoroughly studied before bronchoscopy is attempted as treatment. All allergic manifestations should be investigated and appropriate treatment carried out. A thorough study from the medical standpoint should be made. X-ray examinations of the neck and chest and nasal accessory sinuses should be made. An expert otolaryngologist should eliminate foci of infection in the nose and throat, including the tonsils. The teeth should be thoroughly examined. Even though allergic manifestations may be present, bronchoscopy for treatment may be indicated. (Figs. 5 and 6). Just as the hay fever victim after repeated attacks of hay fever is very likely to develop a purulent sinusitis, so the asthmatic may develop a purulent tracheobronchitis. The purulent sinusitis and the purulent tracheobronchitis may co-exist in the victim of hay fever and asthma. Both should be treated, the sinusitis by the otolaryngologist, the purulent tracheobronchitis by bronchoscopy. Some of our most brilliant results have been in this type of case where the patient has been desensitized by proper treatment and bronchoscopy has cured the purulent tracheobronchitis.

Vaccines. The bronchoscopic removal of uncontaminated secretion from the tracheobronchial tree affords material for the preparation of an autogenous vaccine. In some cases these vaccines have given remarkable results. In all cases the secretions are removed for bacteriological study. Moore and Moffitt have reported very interesting findings in their study of the secretions removed from asthma patients,² and they have prepared a bacteriophage the local use of which has given good results.

Local treatment. There is no local treatment specific for asthma. Local ulcerative lesions may be treated with local applications of a mild character. The use of strong applications of nitrate of silver or the cautery, is contraindicated. One per cent monochlorophenol and albolene may be of some benefit.

The great benefit is obtained from the aspiration of the tenacious secretions which become obstructive. (Fig. 6). In many cases these secretions become so tenacious as to block completely the smaller bronchi. The patient is unable to cough the secretions out. Bronchoscopic aspiration will aid in its removal and often give immediate relief.

CONCLUSIONS

1. Direct examination of the tracheobronchial tree by bronchoscopy is a most important aid in the differential diagnosis of bronchial asthma.
2. Foreign body is a possibility for exclusion, particularly in children. A foreign body lodged in the larynx, trachea bronchi or esophagus may produce asthmatic symptoms.
3. Only direct examination by bronchoscopy will eliminate the presence of organic disease of the larynx, trachea, and larger bronchi.
4. Bronchoscopic aspiration and local medication have been found a valuable aid in cases of asthma with an associated tracheobronchitis. The patients' interest will be served best by the co-operation of the internist, the roentgenologist, the rhinologist, and the bronchoscopist.

REFERENCES

1. Jackson, Chevallier: Chronic Nonspecific Infection of the Lungs, J. A. M. A. 87:727 (Sept. 4) 1926.
2. W. F. Moore: Ciliary Inhibition or Destruction in Tracheobronchial Asthma.

Reaction of Thyroid Gland to Infections in Other Parts of Body

Further work done by Warren H. Cole and Nathan A. Womack, St. Louis (Journal A. M. A., Feb. 9, 1929), on the relation of infections and toxemias to the histologic picture of the thyroid gland confirms their observations concerning the production of hyperplasia, loss of colloid, desquamation and decrease in iodine content in certain septic processes and toxemias. Somewhat similar observations have been recorded by other workers. The authors have developed a toxin containing a group of four organisms which, when injected subcutaneously into dogs, will produce these changes in practically 100 per cent of the animals if iodine has not been ingested by them. The average iodine content of the thyroid or normal dogs is 0.304 mg. per kilogram of body weight, whereas the average iodine content of the thyroid glands of animals dying from severe infections is 0.142 mg. per kilogram of body weight. Similar changes have been observed in the thyroid glands of human beings who have succumbed to acute infections, but these changes are present to a lesser degree. Evidence points to a relation of infections to hyperplastic glands in human beings. Basal metabolic studies made by the authors on animals with hyperplastic glands produced by toxemias and infections have revealed a basal metabolic rate elevated out of proportion to the fever. Injection of toxic doses of histamine produces a marked rise in the metabolic rate, without a significant rise in temperature, and also creates a desquamation, loss of colloid, decrease in iodine content and beginning hyperplasia in the thyroid gland. Injection of toxic doses of an amino-acid (glycocoll) produces the same histologic changes. The pathologic changes already mentioned in the thyroid as produced by infections can be prevented to a great extent by the oral administration of iodine. The data assembled support the theory that the thyroid gland takes an active part in the resistance of the body against certain toxins and infections. In spite of the added information that iodine exerts a protective role in the attack on the thyroid by infections, the authors still feel reluctant to advise the therapeutic administration of iodine to human beings suffering from severe infections.

POST-ENCEPHALITIS*

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Encephalitis and its calamitous results have occupied a great part of the neuropsychiatric literature in the past ten years, innumerable articles having been published up to the present date, many almost contradictory; this probably being due to the fact that the symptoms are numerous and variable, and the etiology as yet very obscure. Any disease which has such a disastrous effect on the mental life of a child would naturally be of intense interest, not only to the medical profession, but to the general public as well. The behavior disturbances commonly found in children afflicted with this condition have produced a pathetic group, and the country as yet has not solved the matter of adjustment. They cannot be kept in schools because of their difficult behavior; they are too intelligent for the feeble-minded institutions; they are too obstreperous for the reform schools. Consequently they are thrown into the State institutions. Children, not technically insane, but with no other institutions available, are thrown into an environment of chronic or acutely mentally diseased adults, usually in the same ward, where the treatment and routine necessary for their adjustment cannot be carried out, thus destroying any possible chance for their recovery.

There will be no attempt to bring out any new facts or theories in this paper. The only object will be to bring to your attention the material which now exists, and to present a few cases which are now, or were, in the Delaware State Hospital, both children and adults. Although general interest in this condition has been aroused only in the last ten years, lethargic encephalitis is probably centuries old. However, the first available accurate report is in 1718, when a case was described in England. In 1916 it became more prevalent on the continent, from there spreading to the United States in 1918, since which time there have been several epidemics, each of somewhat different type symptomatically. In some districts it has become endemic, this being particularly true about New York.

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The acute stage of the disease, or encephalitis, will be first considered. Lethargic encephalitis is an acute inflammation of the brain possibly toxic in character, although the etiology is obscure, which later pursues a chronic course which results in various neuritic and psychotic symptoms without influencing the intellect or moral understanding of the patient; these symptoms being progressive in character, with but slight chance of improvement or cure.

The etiology remains obscure, and the various theories which have been advanced, although interesting and plausible, are disappointing as up to the present time no proof has been advanced. As the epidemics coincided so closely with those of influenza, it was thought that the condition was a complication of this disease. However, encephalitis appeared in Europe before the onset of the influenza epidemic. It is true that influenza may be complicated by encephalitis, but this is not of the lethargic type. It seems more probable that the same environmental conditions favor an epidemic of both types. Some authorities have considered that the disease may be due to a virus. Animal experiments, particularly with rabbits, has shown that this may be true, but since the rabbit seems to be a very unstable animal who produces a well marked case of encephalitis on the slightest provocation, the evidence does not seem to be conclusive.

There are an ever increasing number of cases following vaccination, although no definite connection has as yet been established. Since the symptoms so closely resemble those caused by the spirochete, the lethargia resembling that of African Sleeping Sickness, and the chronic neurological and mental symptoms resembling those of tertiary syphilis, some of the authorities have considered a spirochete as the possible etiological factor, even carrying on treatment on this hypothesis, giving bismuth or sodium iodide, reporting some degree of improvement.

There were three distinct types of onset noticed, each being somewhat peculiar to a definite epidemic—the lethargic, the gastro-intestinal, and the influenzal. Although the onset varied, there seemed to be no characteristic residual symptoms which followed any of the epidemics.

Frequent mistakes were made in the diagnosis of encephalitis so that when neurological symp-

toms appeared months later it seemed impossible to account for them, only careful questioning showing the possibilities of a misdiagnosed encephalitis at some previous date. This difficulty can be readily understood when one considers the symptoms of the acute phase. True lethargia occurred only in one epidemic, becoming increasingly rare in all others until it was seriously considered dropping the name as being unsuitable. The onset was very varied. In some cases prodromal symptoms were noticed for weeks with increasing lassitude and even some change in character before there was a rise in temperature with other signs of an acute brain condition. At times the entire course was that of a slight malaise and drowsiness, with considerable headache. In others grave neurological symptoms with delirium would occur, with death resulting in a few hours. The difficulty in diagnosis occurred when the symptoms resembled those of influenza or gastro-enteritis. All patients having obscure neurological symptoms or marked character changes with a history of having the "Spanish disease" some years or months previous should be viewed with suspicion as they well may have been victims of encephalitis.

Although the three types mentioned are the gross divisions characterizing the epidemics in the United States, ten different types have been described by various authors—1. The somnolent or lethargic. 2. The paralytic. 3. The amyostatic (tremor). 4. The hyperkinetic. 5. The psychotic. 6. The hyper-algesic or painful. 7. The tabetic type with Argyll-Robertson pupils, Romberg, and decreased reflexes. 8. The atonic. 9. The ataxic. 10. The aberrant or intestinal, and the cutaneous. Some of the cases may go on to complete recovery, but the far greater number acquire post—or chronic encephalitis symptoms from a few months to years after the acute attack. It has been estimated that this number is anywhere from 70 to 75%. Even those few cases which apparently go on to complete recovery usually show some difficulty in school work and a lack of general interest following the attack. Acute encephalitis is on the decline since 1923, but the victims of the condition are beginning to appear in greater numbers. Whether this is a chronic or post-encephalitic condition is not determined, as only many autopsies and more careful observation will decide the fact. This

will be discussed a little more in detail later in the paper.

"Chronic encephalitis may be defined as a nervous disease, often of a progressive and chronic character, frequently phasic in its future development, the individual symptoms distinctly indicating the disseminated localization of the morbid process within the central nervous system, with a pronounced predilection for certain definite areas of the same. Therefore one of the chief characteristics of chronic encephalitis is a considerable symptomatological polymorphism, a variability in respect to both the grouping of the symptoms and their mode of development, which is by no means inferior to the clinical pictures of nervous diseases due to syphilis or to that disseminated sclerosis." (Wimmer).

Following the acute stage which has been previously described there may be an interim from a few months to a few years, during which period the patient may remain comparatively free of all disease. Cases without a nervous residue of some type are rare; although it may only be that of a slight facial paralysis. A typical case may be demonstrated as follows: A child who at all times has been apparently normal; interested in his school work, thoughtful of the rights of other people, and well-behaved at home, suddenly begins to play truant from school, loses interest in his work, has violent temper spasms, and even attempts suicide. Careful investigation shows that several years previous he had an attack of "influenza," from which he made an uneventful recovery as far as could be determined. Later, neurological symptoms may develop which show that, instead of suffering from influenza, the child actually had a mild attack of encephalitis unrecognized at the time. The severity of the initial attack seems to bear no correlation to the gravity of the nervous or mental condition following.

The characteristic behavior changes are peculiar to children, actual psychoses rarely developing. They are of such a type that one would prefer to see actual mental deficiency rather than the mal-adjustment that develops from conduct which is absolutely incompatible with social adjustment. These behavior changes are not duplicated by any other known disease, the nearest approach being those occurring in

cerebral trauma. Lesser behavior difficulties may occur in lues and chorea, but the diagnosis is seldom difficult to make in these conditions. The behavior difficulties seem to follow more often the types of encephalitis which are characterized by lethargia and oculomotor symptoms. The victims of this insidious disease are taking places in our reform schools and other institutions for children. They are forming an ever-increasing percentage of the children which are causing problems in our schools. They are coming into our courts where they are mistreated unconsciously, as the difference between their behavior which is due to a disease process, is hard to differentiate from that which is due to maliciousness. Too much stress cannot be laid on the fact that any sudden character change in children of a marked degree should be looked upon with suspicion. Neurological changes may not occur until some months after psychic changes have occurred. In fact, the only neurological change which may occur is that of a slight facial paralysis. Idiocy may develop if the disease occurs before the child is five years of age. The behavior difficulties usually occur between the ages of seven and seventeen. The intelligence in the older children usually remains intact. Although they do poorly in school and in the various psychological tests it is rather due to a lack of initiative than deterioration. Their moral ideas are not lost, their actions being impulsive and uncontrollable with full recognition of the social character of their behavior. But they seem to be unable to control their impulse and even in the midst of their apologies they offend in the same manner. Attempts at suicide are quite frequent in these children, but again the action is unmotivated, they being unable to give any excuse for their rash acts.

This change in behavior in children is probably due to the fact that the brain is still immature and the character habits not firmly established. There is a great variation in symptoms, no two cases coinciding. The child may be hyperkinetic, and garrulous. His attention may become erratic. There may be uncontrollable outbursts of crying or laughing. There may be irritability, with marked temper tantrums during which there may be attempts at homicide. The use of abusive language and destructiveness are not uncommon. The children may become habitual truants, pilfering and begging. All these

symptoms as in adults are associated with bradyphrenia, or extreme fatigability of initiative interest and psychomotor activity. The psychic symptoms may run a definite course, the period of most excitability occurring at night while the patient remains more or less drowsy during the day. The changes may be almost clock-like in character.

The psychic symptoms in adults are markedly different than those found in children. If character deterioration occurs in adults, which it rarely does, it usually denotes a previous psychopathic personality aggravated by the disease process. Headaches and insomnia with drowsiness during the day may occur. A tachycardia, bradycardia or both associated with precordial pains are found.

The neurological symptoms are more easily recognized. Paralyzes or semi-paralyzes of any of the cranial nerves may be monosymptomatic, that of the facial nerve being the most frequent, Parkinsonism is the most marked emerging almost directly from the febrile stage, although it too may follow an afebrile attack or delay several months before its appearance. There is an increasing hypertonicity of the muscles with the typical facial expression of paralysis agitans. There may be such a difficulty in passing from a state of rest to activity that a condition resembling catatonic dementia praecox may result. Automatic movement may occur without difficulty. In contrast to paralysis agitans there may be no tremor or if it is present it is not accentuated by active movement. Bradyphrenia is frequently present but this must not be confused with the laziness due to the stiffening of the muscles. Laziness of speech may result in mutism which disappears in reciting or reading which is more or less automatic. In fact, it appears to be more of a laziness in thought. Spasmodic speech and explosive laughter occur which are not found in true parkinsonism. There are intermediary neurological types which are less clearly defined and therefore offer considerable difficulty in diagnosis. The picture may resemble that of a cerebral tumor, cerebral syphilis, disseminated sclerosis, cerebral hemiplegia, apoplectiform seizures without coma, asphasia, or epileptiform or tetaniform attacks. The condition may closely resemble rabies with Argyll-Robertson pupils, positive Romberg and decreased reflexes. In

discussing the neurological symptoms the respiratory disturbances must not be overlooked. These are fairly frequent and characteristic, at times being monosymptomatic. There may be an increase in rate (polypnea) although bradypnea has been recognized less frequently. The disturbances are hysteriform in character, usually periodic and manifested by disturbances in rhythm, coughing and respiratory tics.

Other neurological disturbances are less common. The epidemic of hiccupping which was prevalent some time ago has been shown to be encephalitic in character. Speech disturbances are variable, almost all types being found. Cerebellar disturbances may result in vertigo or disturbances in gait. Various abnormal involuntary movements occur, and sensory disturbances may become so acute that they resemble neuritis.

The effect on the endocrine system is indefinite, all glands being affected rather than an individual gland or a group. Extreme obesity has been known to follow an attack of encephalitis.

The spinal fluid findings are not characteristic. A slight luetic curve is the one most frequently reported in both the acute and chronic forms, although the meningitic curve has occurred. The pressure may or may not be increased. The sugar content is usually but not always increased. The Wassermann is negative as a rule, but there are a few cases on record in which it has been definitely positive.

The psychotic symptoms in adults are diffuse and varied. Blurred consciousness frequently occurs. Depression may reach that of an attempted suicide or an actual carrying out of the act. This differs from a clear cut manic depressive psychosis in that there is no element of self-condemnation. It must be remembered in discussing the psychosis that a latent predisposition to insanity may be precipitated into an active case by the encephalitic infection. Therefore one must not be too rash in diagnosing a post-encephalitic psychosis even if the history of encephalitis is fairly clear. It is well to eliminate all other forms of psychosis first, and also to take into account the normal psychic makeup of the patient.

The inhibition due to the characteristic bradypnea may closely resemble dementia praecox, but careful observation will determine the diagnosis. The symptoms in chronic encephalitis are

due to a lack of initiative, while those in praecox are due to negativism. All the abnormal actions are inward or in the patient's own psyche, while those of praecox are projected, the patient blaming his acts upon some outward force. Finally, the encephalitic's actions and conversation are of pure rationalization, while those of praecox are of symbolism. The encephalitic still retains many of his inhibitions while the praecox has lost all of his.

Other various minor disturbances are seen, such as hypochondriases impulses and obsessions. The disease process acts on the psychic life differently in different personalities, the makeup of the individual probably determining the type of mental change the patient will undergo.

In passing one might say a few words regarding the effect of encephalitis upon pregnancy. It is generally decided that pregnancy produces an exacerbation, but the children resulting from these pregnancies are apparently normal, although there has been no definite research done on any of them after infancy.

These conditions were formerly known as post-encephalitis. It has been determined that the disease usually runs a nonfebrile course, but there may be short febrile attacks, periodic in character, which closely resemble the acute stage. It seems that the disease apparently remains latent until the time remains right for a recurrence, somewhat resembling tertiary syphilis in this connection.

The prognosis is exceptionally poor. Since the cause is obscure no specific treatment has been found. The behavior and psychotic types must be institutionalized. In children a definite regime is carried out which fills the entire day. Some of these children learn to adjust a slight bit better in the group, but on releasing them from the institution they seem to have an immediate relapse. Hyoscin and bromides have been given in the hyperkinetic and the neurological types with rather doubtful results. Until the specific cause is found the treatment will have to be merely symptomatic while definite mental training is carried on to encourage them to adjust as well as possible.

I will now present a few cases in the Delaware State Hospital, demonstrating as well as possible the various types found.

CASE 1.—L. P.

Aged 23 years, admitted June 20, 1927. History states that this patient was delusional, incoherent, depressed, and hallucinated. Physical examination showed that the patient was emaciated. Neurologically the deep reflexes were decreased on the right side. Pupils were slightly contracted, with sluggish re-action to light.

History—In December 1926, patient suffered from an acute condition, variously diagnosed as influenza, streptococcic sore throat, and appendicitis. She was in the hospital two months, during which time she showed mental symptoms, and was definitely suicidal.

At the hospital the blood Wassermann was found negative. Temperature varied from 96 to 99 axillary. Pulse varied from 50 to 100.

While here the patient was confused, depressed, and probably hallucinated. Improved rather rapidly until the date of discharge, in August 1927. Patient has been under observation since, has remained apparently normal.

Discussion—We have here a case of Psychosis, emerging directly from the Acute Process. Patient was decidedly in confused state, incoherent, and as far as could be determined, hallucinated. She made a complete recovery, with the exception of a few slight peculiarities.

From the history and a typical mental condition, the diagnosis of Encephalitis was made. Whether permanent neurological symptoms will later develop cannot be determined at the present time.

CASE No. 2.—D. A.

Aged 14 years, admitted May 28, 1928. Brought from the Ferris Industrial School with a history of speech defect, attempted violence, homicide and suicide. Facial expression, rather masked. Paralysis of the left side of the face. Partial paralysis of the palate and throat. Deep reflexes increased. External strabismus of the left eye. Open mouth, drooling, occasional staggering, and a difficulty in associated movements.

Four years previous patient had an attack of "sleeping sickness." Slept for one week, and for two months after was drowsy and sleepy all day long. Since this time family noticed change in disposition. Became easily excitable, but not

without provocation. Attempted suicide. Sent to Ferris Industrial School after he had attacked his aunt with a bread knife. Caused trouble in school. Attempted homicide. Became a dangerous character. At the hospital laboratory tests were negative.

Course—Patient adjusted well for awhile, but now is becoming more difficult to handle, although he has committed no serious offense as yet.

Discussion—We have a rather clear-cut case of chronic encephalitis with behavior and neurological symptoms. During his controlled moments he is pleasant and attempts to please. Although definitely retarded there seems to have been no evidence of a progressive deterioration. It is this type which is causing the most difficulty at the present time, as no means have been evolved of controlling the temper tantrums.

CASE 3.—C. L.

Aged 13. Transferred from the Feeble-Minded School at Stockley, May 10, 1928.

History—Violent and destructive to clothing and furniture. Decided temper tantrums, quarrels, cries easily. Slaps, bites, kicks, screams and swears. Awkward, cannot help himself to any extent. Jumped twenty feet to cement pavement while in Pennsylvania Hospital. At four years of age he had influenza. Ran a high temperature. He improved, then became suddenly worse for a month, running a high temperature. Extremely ill, slept much, had to be fed, never opened his eyes. Some months afterward began showing definite behavior changes. Laboratory tests negative.

Course—Patient was in Pennsylvania Hospital. Made some adjustment in a group. Was removed by his mother. Later sent to School for Feeble-Minded at Stockley, where it was impossible to handle him. Transferred to Delaware State Hospital. For awhile when the environment was new, he adjusted again fairly well. For the last few weeks his temper tantrums have been particularly violent. Has attacked the attendant on many occasions. Been destructive to clothing. Has shown no improvement.

Discussion—This is one of the cases in which it was thought that sleeping sickness or encephalitis followed influenza, as it gives an apparent definite connection between the two diseases. He

is a typical case of behavior difficulty occurring in a child. His early history shows that he had enuresis to quite a late age, and therefore was somewhat unstable. Whether this has anything to do with the fact that he developed into a behavior case or not, is not known. His temper tantrums are so violent that it takes two or three attendants to subdue him. He has good insight into his condition. Realizes that he has done wrong. Is sorry after he has been violent, but is apparently unable to control himself. This type of encephalitis re-action is found only in children, between the ages of 7 and 16.

CASE 4—S. B.

Aged 42, admitted January 20, 1928. Patient suffered from depression, irritability and incoherence. Vulgar and obscene, and at times violent. On admission patient was semi-comatose. A few days later physically negative. Reflexes normal. Three months later reflexes on the right side exaggerated.

Patient's attack occurred suddenly, week before admission. Refused to eat or take medicine. Sleeping a great deal, and when not sleeping would talk incessantly. Had ideas of reference.

Progress—Patient improved from her semi-comatose condition very rapidly. Used very infantile language. At the present time shows no evidence of deterioration. Is markedly unstable emotionally, laughing foolishly and crying without cause. Interested, active, resembling the manic type of psychosis in her re-actions, but has no ideas of self-condemnation.

Discussion—This is a case of Psychosis following encephalitis of manic-like character. Shows no tendency to recover beyond the point she has reached. Is more hypomaniacal in her re-actions. Entirely extraverted.

CASE 5—E. G.

Aged 39, admitted April 10, 1928. History of depression, exaltation, disorders of memory, incoherence. On admission patient had tabetic gait. Speech hesitating. Pupils dilated. One slightly larger than the other, re-acted sluggishly to light, and accommodation. Positive Romberg. Reflexes exaggerated. Somewhat incoherent, had delusions of persecution colloidal gold 4444331000. Blood and spinal fluid Wassermann negative. Disoriented as to time but oriented well in all other fields.

Past history—Said she had influenza, suffering severe headaches last thing she can remember. Claims she was very drowsy and sleepy; after an attack of influenza could not do her work properly. Became more irritable and fault-finding. Complained of severe headaches just before onset of psychosis.

Course in hospital—Patient adjusted well. All neurological symptoms cleared. Apparently made complete recovery without any antisyphilitic treatment.

Discussion—This is probably tabetic type of encephalitis psychosis, being immediately superimposed upon the encephalitic process, which was mild, as she complained of only severe headaches. Patient reports to the hospital, apparently perfectly normal, working, and adjusting well at home.

CASE 6—M. S.

Aged 19, admitted April 20, 1928. Convulsions until 16. Retarded in school.

History—Disorders of memory after childbirth, tried to kill baby. Incoherent. Statement from the hospital says that patient was absolutely normal on leaving the hospital. No evidence of psychosis. Obstetrician states that childbirth did not affect her mental condition. March 19, she had postpartum condition, was depressed, but no other symptoms were exhibited.

Physical examination—Complains of headache. Reflexes increased on left side, right side normal. Slight paralysis of the left side of face. May 9, right pupil larger than left, re-act sluggishly to light. Blood Wassermann negative. Temperature ran from 96 axillary to 98.6. Pulse varied from 50 to 100. Respiration remained around 20. At this time complained of severe headache, was chronically constipated.

Patient is confused, disoriented. Changed from normal reflexes to abnormal. No evidence of hallucinations, delusions. Refuses to talk most of the time. Patient ran a peculiar course for some time from normal to pathological neurological symptoms. At the present time she resembles closely praecox. However, she is not introverted to such an extent. Her lack of activity seems to be more of a mental and physical laziness rather than an inhibition. She has not at any time been a behavior difficulty. Diagnosis — Post-

Encephalitis, with Psychosis was made, psychosis resembling very closely that of a praecox.

CASE 7—R. H.

Aged 38, admitted September 21, 1927, brought from a hospital where she was admitted September 6, 1927, supposedly suffering from convulsions, from which she made a complete recovery. A few days before her admission to Delaware State Hospital she became noisy, violent and disturbed, suffering from hallucinations of sight, and incoherence. Admitted to this hospital, temperature 102. Diagnosis of some toxic psychosis made at the time. Pulse 160. Speech very indistinct. Scanning voice. Mouth very sore. Second day could talk some, but not well. Unable to walk. Reflexes exaggerated. Patient had a coarse tremor, almost choreiform in character. Pupils dilated, no re-action to light.

Patient after the first few days kept on improving steadily. Showed no mental symptoms as soon as the acute confused state cleared. However, neurological symptoms remained. She is showing some improvement in neurological symptoms, although they are still present to a marked degree.

Discussion—Case of acute encephalitis with delirium at the time of the acute attack. No psychosis. Blood Wassermann two plus. Spinal fluid Wassermann negative. Differential diagnosis between multiple sclerosis and general paresis was considered. Patient improved too rapidly for multiple sclerosis. She received a couple of injections of arsphenamine, but had a localized arsenical reaction from the treatment, and it was discontinued. The recovery from the acute process was too rapid to confirm either diagnosis. Diagnosis, after considerable discussion and examination, Post-Encephalitis, at the present time without psychosis.

The future of these cases is still somewhat of a mystery. The out and out psychoses will be cared for in our state institutions, but the cases showing purely behavior difficulties are a problematic case for which there is no solution at the present time. As the cases increase it will be necessary to build special institutions where they can be cared for with proper teaching and recreation. Pennsylvania has worked this out to some extent by opening a ward to care for these cases. Here their day is carefully planned and they

work and play on schedule. Although there are apparently no cures, the children learn to adjust fairly well in their group. They do productive work of some kind and are in much better condition than if they were allowed to remain at large or than if they were placed in reform schools, which is so often the case at the present time. There is no one else to carry the burden except the State, and it seems to be time that the problem be seriously considered and solved. They are a menace to the community at large, they are not true offenders because they are diseased and therefore not responsible for their actions. Some place should be built for them where they could be well taken care of and where all effort should be made to improve their adjustments even if a cure seems to be impossible at the present time.

BIBLIOGRAPHY

- Robert F. Sheehan, Epidemic Encephalitis. Archives of Neurology and Psychiatry, January 1928.
 Harry C. Stores, Clinical Aspects of Epidemic Encephalitis. Archives of Neurology and Psychiatry, January 1928.
 Edward A. Strecker and Gordon F. Wiley, Epidemic Encephalitis, page 631, Volume 4, American Journal of Psychiatry.
 Emily Smith Jelliffe, American Journal of Psychiatry, Volume 6.
 Earl D. Bond and G. E. Partridge, Post-Encephalitis Disorders in Boys and their management in a Hospital. American Journal of Psychiatry, Volume 6.
 August Wimmer, Chronic Epidemic Encephalitis, 1924.

Acute Miliary Torulosis of Lungs

Edwin F. Hirsch and George H. Coleman, Chicago (Journal A. M. A., Feb. 9, 1929), report on a case of acute miliary torulosis of the lungs. In cultures of the spinal fluid and in blood from the right ventricle of the heart removed during the postmortem examination, Torula histolytica was isolated. They state that acute miliary torulosis of the lungs follows a blood stream dissemination of the torula organisms from some chronic lesion. Although other reports mention chronic changes of the lungs, their case seems to be the only one in which all of the lung changes were acute. The chronic lesions from which the torula organisms were liberated probably are those in the meninges or tissues of the middle cranial fossa. The location of these about the gasserian ganglions and the middle meningeal arteries suggests that the infection of the meninges has extended along these structures from the nasopharynx.

EDITORIAL

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VOL. I

FEBRUARY, 1929

No. 2

THE NEWTON BILL

The bill pending in Congress to continue the work of the soon-to-die Sheppard-Towner Act, is meeting with the almost unanimous opposition of the medical profession, especially that portion of it that keeps itself well-informed on public questions and matters of legislation. Of more than passing interest to the profession in Delaware, therefore, are the remarks of our President, Dr. La Motte, before the Kent County Medical Society, at the meeting of February 6, 1929, in Dover. Delaware has but one Congressman, so the vote of this state in the House of Representatives begins and ends with the action of Mr. Houston, who already appears to have gone over to the enemy. But—let the President speak in his own language:

I wrote your secretary I did not want to talk and preferred to make just an official visit. However, as President of the State Medical Society, a unit of the greatest medical organization the world has ever had, it is my duty not only to be here but to try to say something, particularly when called upon. It is the duty of every worthy physician to support his State association, and the duty of the State association to support the great American Medical Association, an association with a membership of more than 96,000 physicians, and doing such magnificent work in so many departments.

Our Society always elects a Committee on Public Policy and Legislation. That committee should lead in securing the enactment and enforcement of just medical laws. They are the ones who should be informed in these matters and be on hand when needed, and if they do not intend to, or see they cannot, then they should not accept the responsibility. They should be on the lookout not only in their state legislature, but also Congress should be watched. I will refer to a bill that is now pending in Congress. Now, I do not believe I have met a doctor from coast to coast, with the exception of one or two working under the Sheppard-Towner Act, who has not been opposed to the Sheppard-Towner Maternity Act, and now there is likely to be passed by Congress a more radical bill called the Sheppard-Towner-Newton Act. To illustrate our position I will read some communications between our Congressman and myself.

"Dear Mr. Houston: The doctors of Delaware would appreciate it if you would be on the lookout for the Sheppard-Towner-Newton Maternity Act. This is a vicious piece of legislation, and every doctor in your State is opposed to it."

"My Dear Doctor: Your letter of January 24th advising me of the opposition of the doctors of Delaware to the Sheppard-Towner-Newton Act received. I regret that my constituents are very much divided upon this bill. While the doctors are opposed to it, the women all seem to be in favor of it. I will give the matter careful consideration."

"Dear Mr. Houston: I wish to thank you for your letter of January 25th in reference to the Sheppard-Towner-Newton Act. I beg to ask you whom you think are more capable in deciding the merits or demerits of a maternity problem, physicians of the country who have spent and are spending years in the study of such matters, or the women of the country, many of whom are influenced in such matters by emotionalism? I have always felt that when experts are of one opinion on a question, those who have never made a par-

tical study of the problem have absolutely no right to differ from the experts. Whenever a medical problem is socialized you will find scientists will lose their incentive for research and a dampening if not an entire loss in their interest of those who most need their study and care will result. I cannot understand why so many law-makers of our country listen so much to hysteria and so little to intelligence and authority. This is not personal, because I do not believe you come under that category, but I know that many do, either through ignorance or fear. I beg of you at least to hear and get others to hear the medical side of medical questions, particularly from those who represent the American Medical Association which represents the medical profession of the whole country, which has done and is doing so much for the welfare of the citizens of the whole United States, and, in many instances to the detriment of the financial interests of the profession."

"My Dear Dr. La Motte: Yours of January 29th received. My father was a physician, and being raised in that atmosphere, I am thoroughly acquainted therewith, and I have the highest regard for the position of physicians generally, but of course they themselves would not claim that they are infallible. We are always placed in an embarrassing position when our constituents disagree and are compelled to follow our own personal judgment, which, of course, is not infallible, in our final decision. I shall give this bill careful consideration and reach a determination which I shall conclude will be best for all concerned."

This bill turns over to one agency, the Children's Bureau, the conservation and promotion of the health of selected classes, while leaving to another agency, the Public Health Service, the conservation and promotion of the health of the community generally, including the very same classes entrusted to the bureau named. This is calculated to lead to inefficiency, confusion and wasteful duplication of effort, particularly when from the standpoint of health one of the agencies is a lay agency and the other is not. Even the Sheppard-Towner Act conceded the right of the state to control infant and maternal welfare within its borders. The Sheppard-Towner-Newton Maternity Act, from information I gather, denies this and authorizes federal activities in the state independent of the state. If, however, there is to be federal interference or control it should be brought about through the federal service organized and built up for the discharge of health functions, namely, the Public Health Service.

"The Sheppard-Towner Act is self-limited; the pending bill seeks to establish a permanent policy. The Sheppard-Towner Act requires that every project, before being adopted, be approved by a board consisting of the surgeon-general of the Public Health Service, the chief of the Children's Bureau, and the commissioner of education; the

pending bill substitutes for this a board devoid of authority and with advisory functions only, with which the chief of the Children's Bureau may or may not consult, as she sees fit, and whose advice she may reject or accept at her pleasure. The chief of the Children's Bureau is to be the chairman of the board and to appoint five of its nine members, while the commissioner of education, the surgeon-general of the Public Health Service and the director of extension work of the Department of Agriculture make up a minority of three." —(From editorial in *Journal*, A. M. A., Dec. 1, 1928.) What if an Emma Goldman or a Mrs. Levine should become head of this bureau?

If you are for this Act, say so, if you are opposed to it, get busy! And to be effectively busy in such matters you have to do a little missionary work and educate the public. Women are a power now in this country, and clubs in many instances are educated by propagandists and faddists. Very frequently they hear only one side of questions that are medical, while we physicians stand by and say nothing until it is too late. Let us make our representatives in both houses of Congress know very definitely just where we, as physicians, stand on this important bill.

MENTAL HYGIENE CLINIC

We are living in a highly complex world, that requires many adjustments for which the natural human instincts supply but poor material with which to work. In pre-historic times when all people had practically the same environment, consisting of the same social standing, the same education; when there was no confusion, and disease was a minor problem, nature sufficiently endowed her subjects to meet the daily difficulties. But as man began progressing, he developed his material life much more rapidly than his psychic life. In primitive times mental deficiency was no great problem, because life itself was simple, and required no great amount of intelligence to make it successful. Psychopathic personalities were not recognized if they were present, because there were no fine adjustments to be made with life.

But in our present civilization, with group life predominating, as in our schools, churches, at work, and so forth, it became a daily problem as to how the individual would use the material with which nature had endowed him, in order to make the proper necessary contacts. Every community contains many individuals who have been unable to do this. These are aberrants from the generally

accepted normals, and have the same right to the help of society as if they were actually insane. They deserve the help of society because it was through society that they were forced into their present environment, for it is society alone, as a whole, that determines our living conditions.

It is only through psychiatric observation and mental hygiene clinics that this help can be given.

Nearly all states have such departments and clinics where advice is given to those in need, where more serious cases (possibly psychotic), are held and studied; where an attempt is made to give the nervous and backward child a chance in life, and where mental cases are studied before they are legally committed. Many hospitals have psychopathic wards, but since Delaware is a small state, no point of which is out of easy reach of all other points, it seems as if it would be better for economic reasons to have this centralized in one building, which will take care of the entire state.

The establishment of a psychiatric observation clinic, and of a mental hygiene clinic, was discussed at the Annual Meeting of the Medical Society of Delaware in October 1927. Since then, the question has been studied carefully, and as the result of this study a bill has been presented to the Legislature at this session. This bill calls for the establishment of a mental hygiene clinic, and for the building of a psychiatric observation clinic, to be under the control of the state.

It is to be hoped that every physician and citizen will recognize the importance of the passage of this bill.

Soft Eyeball (Hypotonia Bulbi) in Diabetic Coma

Arthur J. Patek, Milwaukee (Journal A. M. A., Feb. 9, 1929) reports on five cases of soft eyeball (Hypotonia bulbi) in diabetic coma. He states that hypotonia bulbi is not found in comas other than those of diabetic origin. Constancy of the sign in diabetic coma is not conceded, but the assertion is made that it is present with striking frequency. It is absent in diabetic acidosis without coma. The hypotonia is most pronounced at the height of coma, and quickly recedes as the coma is overcome. The eyeball tension may not be lowered an equal degree in the two eyes. In the five cases seen by Patek the reduced tension of the eyeballs in diabetic coma proved itself of diagnostic value.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

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The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

The subject of physicians' fees is again under discussion, especially in the New Castle County Medical Society, where a committee has been appointed to suggest a new fee schedule for visits after evening office hours, at night, etc. It appears that, in Wilmington at least, the charges for such services are too low and that a revision upwards is in order. Those who have given the matter the most thought are convinced that the public, when properly informed, will readily see the justice of the proposed revision.

As a corollary of the above, the matter of physicians' collections is also in mind. Probably no other creature on earth is compelled to write off as profit and loss (chiefly loss) as large a percentage of his gross business as the doctor. And this not only in the lean years, but in each and every year. In Wilmington, the city which leads the world in per capita wealth, the annual losses are amazing. There should be some way to remedy this, and of the various schemes so far proposed we are strongly of the opinion that a Credit Bureau, owned and operated by the physicians and dentists, offers the best, safest, and most economical way of bringing the chronic dead-beat to terms. This matter will be fully discussed later.

The city of Detroit is wide awake, but nothing of recent times gives better evidence of this ultra-

modernity than the arrangements made with the telephone company, whereby in the yellow section of the directory, under "Physicians and Surgeons" will be listed "members of the Wayne County Medical Society." Beneath this list will be found those who are not members of the medical society, thus giving the Detroit public the opportunity of selecting a physician with some discretion. Our congratulations to Wayne County.

In similar vein, our congratulations and very sincere thanks, to the editors of the Wilmington daily press, who are running daily, for nine days, a series of articles under the heading "What the Public Should Know About Cancer." These short stories cover the chief regions of the body, were written by Dr. Bloodgood, and are published under the authorization of the Delaware Committee of the American Society for the Control of Cancer, together with the Cancer Committee of the Medical Society of Delaware. We are very fortunate in having in our midst such forward-looking editors.

"The path of glory leads but to the grave." Captain Fried, hero of every household, has been inveigled into signing huge advertisements telling of the boon a certain brand of cigarettes were to the crew of the life-boat that rescued the men of the Florida. He even made similar utterances over the radio. The cash gained thereby may be a lucky strike for the captain, but he had better pass up such sweets. Somehow, it seems to us, part of the glamor and heroism of his wonderful rescue has been taken away from him by those who advised him in this commercial course. We devoutly hope his path of glory may not lead again to such a grave error.

MISCELLANEOUS

NEW EXECUTIVE SECRETARY FOR STATE BOARD OF HEALTH

Doctor Arthur T. Davis having resigned as Executive Secretary of the State Board of Health to accept a position as County Health Officer for Suffolk County, New York, the State Board of Health, at a meeting on December 13th, elected Doctor Arthur C. Jost, Executive Secretary to take office on January 1, 1929.

Doctor Jost has had more than twenty years experience along public health lines. He is a graduate in Arts from Acadia University and in Medicine from McGill University at Montreal. For a number of years he has been County Health Officer in the Province of Nova Scotia, and for the past ten years has been in the Provincial Health Department of the Province of Nova Scotia—the past six years of which he has been Health Officer and Registrar of Vital Statistics for the Province. He has also been a lecturer on Hygiene in the Dalhousie University College of Medicine, and an examiner for the Medical Council of Canada. He is a member of the American Public Health Association, the Conference of the State and Provincial Health Authorities of North America, the Canadian Medical Association, the British Medical Association, and the Canadian Public Health Association.

During the World War he served three years with the Canadian forces in medical administrative work, being discharged with the rank of Lieutenant Colonel in the Medical Corps.

He therefore brings a wide experience to take up his duties as the Executive Secretary of the Delaware State Board of Health.

FOOD INDUSTRIES PREPARING DEFENSE AGAINST CIGARETTE PROPAGANDA

The National Food Products Protective Committee has taken a wise and sound stand in its campaign to offset the Lucky Strike advertising. The Committee has made it clear that it has no quarrel with the tobacco industry as a whole and no desire to interfere with fair and ethical methods of promoting the sale of cigarettes. Its energies are directed to combating the claims of the American Tobacco Company that people will be better off if they eat less sugar-flavored foods and smoke Lucky Strike Cigarettes instead.

One of the most interesting sidelights on this is the protest filed with the Federal Radio Commission by the United Restaurant Owners' Association. Dr. Olin West, secretary and general manager of the American Medical Association, wrote to Joseph Burger, president of the Restaurant Association, as follows:

"The American Medical Association is greatly interested in the matter of undesirable advertising for which purpose radio seems to be more and more widely used. We have communicated with the Federal Radio Commission voicing our opposition to some of the practices which are now permitted."

With this we agree. We also agree with the thought that cigarette smoking among minors is to be discouraged. Our attitude on sugar has been made abundantly clear. It is a useful food, an essential in its place, but also subject to abuse. We did not and still do not see any harm in reaching for a Lucky instead of a sweet in the case of the obese and when both are luxury indulgences, not concerned with necessary nutrition.

But it is to be feared that the situation has gone beyond that. There is evidence that the harmless-appearing but deadly questionnaire has been put to work again, and recently several hundred insurance doctors were given the appearance of expressing themselves on the subject in a form and manner which one can hardly believe they intended.

This office has been the recipient of several letters of apparently harmless inquiry that, however, somehow offended sensitive nostrils. Whatever the merits of this particular case, it is time that a stop should be put to the growing practice of using the physician as a catspaw and to the unwarranted exaggeration of the health angle in the advertising of often highly questionable claims with the introduction "Your Doctor says" or "Doctors recommend."

It is time that the doctor should say what he really thinks, openly, in print and by broadcasting really sound facts pertaining to the health angles which the advertising agencies now exploit to the greater glory and wealth of their clients, though perhaps far less to the health and wealth of those upon whom they claim to be conferring blessings.

As a first step, let the physician stop once and for all answering questionnaires of dubious merit, with or without strings or appurtenances attached.

As a second step, let him organize through his county societies, or his journals a really honest and sound radio campaign. *Selah!*

American Medicine.

BOOK REVIEWS

Woman: Her Sex and Love Life. By William J. Robinson, M. D. Seventeenth Edition. Cloth. Pp. 411, with 10 illustrations. Price, \$3.00. New York: Eugenics Publishing Company, 1929.

This is a new edition of a work that has been before the lay public since 1917. It contains chapters on the anatomy and physiology of the female genitalia, pregnancy, venereal diseases, marriage, and kindred subjects. It is written in homely language that any layman can understand. There are statements with which we cannot altogether agree, but on the whole the book deserves its popularity.

Birth Control. By William J. Robinson, M. D. Thirty-second Edition. Cloth. Pp. 254. Price, \$2.00. New York: Eugenics Publishing Company, 1929.

Any book on a medical subject, written for the laity, that reaches thirty-two editions, is either a most valuable and impressive work, or has attained popularity through clever tactics. In the instant case, we believe the popularity is due to the latter, in fact, the title alone would mean large sales; but, while the book contains some valid arguments in favor of birth control, it, of course, does not describe the technique, for the very good reason that the law forbids. We fear that an anxious public will be disappointed in it.

Death of Author of First Law to Control Ophthalmia Neonatorum

Dr. Lucien Howe, noted ophthalmologist and father of the first law for the control of ophthalmia neonatorum, died in Belmont, Massachusetts, on December 27 at the age of eighty.

In 1890 Dr. Howe was successful in having the New York Legislature pass a law requiring the reporting of sore eyes in babies. Maine, which has been credited with passing the first law of this nature in the United States did not take similar action until 1891. In 1892 the New York Law was changed to require the use of a silver nitrate or some equally effective solution in the eyes of new-born babies.

The meeting of the New Castle County Medical Society to be held at the University Club, Wilmington, at 8.30 P. M., March 6, 1929, will be addressed by Dr. Frank Croger Knowles, Professor of Dermatology at Jefferson Medical College. His subject will be: "Diseases of the Skin Due to External Causes." All physicians are welcomed at these meetings.

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